80.4.4 The per diem limit shall be the median plus 10 percent for facilities fiscal year beginning on or after July 1, 1995.

80.4.5 Each facility's Base Year Indirect Patient Care cost per diem rate shall be the lesser of the limit set in subsection 80.4.4 or the facility's base year per diem allowable indirect patient care costs.

80.5 ROUTINE CARE COST COMPONENT

Routine Care Cost component base year rates shall be computed as follows:

80.5.1 Using each facility's base year (fiscal year beginning on or after 10/1/92) cost report, the provider's base year total allowable routine care costs shall be determined in accordance with Section 43.

80.5.2 The base year per diem allowable routine care costs for each facility shall be calculated by dividing the base year total allowable routine care costs by the total Base Year resident days.

80.5.3 The Bureau of Medical Services will array all nursing facility's base year per diem allowable routine costs adjusted to a common fiscal year by the appropriate inflationary factor, from low to high and identify the median.

80.5.4 The per diem limit shall be the median plus 8 percent for fiscal year beginning on or after July 1, 1995.

80.5.5 Each facility's Base Year Routine Care cost per diem rate shall be the lesser of the limit set in Subsection 80.5.4 or the facility's base year per diem allowable routine care costs.

80.6 RATES FOR FACILITIES RECENTLY SOLD, RENOVATED OR NEW FACILITIES

80.6.1 A nursing home project that proposes renovation, replacement or other actions that will increase Medicaid costs and for which an application is filed after March 1, 1993 may be approved only if appropriations have been made by the Legislature expressly for the purpose of meeting those costs. The basis for establishing the facility's rate through the certificate of need review is the lesser of the rate supported by the costs submitted by the applicant or the statewide base year median for the direct, indirect and routine cost components inflated to the current period. The fixed costs determined through the Certificate of Need review process must be approved by the Bureau of Medical Services (also see Section 44.25.2).

80.6.1.1 For a facility sold after October 1, 1993, the direct, indirect and routine rate shall be the lessor of the rate of the seller or the rate supported by the costs submitted by the purchaser of the facility. The fixed cost component recognized by the Medicaid program will be determined through the

Certificate of Need review process. Fixed costs determined through the certificate of need review process must be approved by the Bureau of Medical Services.

80.6.2 Nursing facility's not required to file a certificate of need application, currently participating in the Medicaid program, that undergo replacement and/or renovation will have their appropriate cost components adjusted to reflect any change in allocated costs. However, the rates established for the affected cost components will not exceed the state median rates for facility's in its peer group. In those instances that the data supplied by the nursing facility to the Department indicates that any one component rate should be less than the current rate the Department will assign the lower rate for that component to the nursing facility.

80.6.3 The reimbursement rates set, as stated in Sections 80.6.1 and 80.6.2, will remain in effect for the period of three (3) years from the date that they are set under these Principles.

80.6.4 At the conclusion of the three years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1, 42.1, and 43 or the most recent audited fiscal year occurring after the opening of the new facility, the completion of the new renovation, or the sale of the facility, whichever is the most current.

80.7 NURSING HOME CONVERSIONS

80.71 In reference to Public Law 1981, c. 705, Pt. V, § 304, the following guidelines have been established in relation to how nursing facilities that convert nursing facility beds to residential care beds will be reimbursed:

80.71.1 A proforma step down cost report for the year in which the bed conversion will take place or the first full fiscal year in which the facility will operate with both nursing facility and residential care facility levels of care will be submitted to the Bureau of Elder and Adult Services and to the Division of Reimbursement and Financial Services of the Bureau of Medical Services.

80.71.2 Based on an analysis of the cost report by the Department, the allowable costs will be determined based on the Principles of Reimbursement for Nursing Facilities contained herein.

80.71.3 The occupancy level that will be used in the calculation of the rate will be set at the days included on the pro forma cost report submitted at the time of the conversion or at the 97% occupancy level, whichever is greater. For conversions with an effective date of July 1, 1998 or after, the occupancy level that will be used in the calculation of the rate will be set at the days included on the pro forma cost report submitted at the time of the conversion or at the 95% occupancy level, whichever is greater.

80.71.4 The case mix index will be determined as stated in Sections 41.2 , 80.3.1, 80.3.2, 80.3.3.2, and 80.3.4.1.

80.71.5 The upper limits for the direct, indirect, and routine care cost components will be inflated forward to the end of the fiscal year of the proforma cost report submitted as required in Section 80.71.1.

80.71.6 The reimbursement rates set, as stated in Sections 80.71.1 -80.71.5, will remain in effect for the period of three (3) years from the date that they are set under these Principles. The direct, indirect, and routine components will be inflated to the current year, subject to the peer group cap.

80.71.7 At the conclusion of the three years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1, 42.1, and 43 or the most recent audited full fiscal year occurring after the conversion of nursing facility beds to residential care beds, whichever is the most current.

80.71.8 Section 80.7 is effective for Nursing Facilities with the effective date of conversion of nursing facility beds to residential care facility beds occurring on or after January 1, 1996.

81 INTERIM AND SUBSEQUENT RATES

81.1 Interim Rate and Subsequent Year Rates. Fifteen days prior to the beginning of the facility's fiscal year, an interim rate will be established by using the fixed cost component of the previous fiscal year and adding to it the inflated indirect and routine cost components of the base year. The interim rate in subsequent fiscal years will be determined in the same manner as outlined above. The direct cost component is computed as specified in Section 80.3.4.

82 FINAL PROSPECTIVE RATE.

Upon final audit of all nursing facility's base year cost reports, the Department will determine a final prospective rate. The final prospective rate will be used as the basis for determining any adjustment that is required to adjust the computation of the median and upper limits for the indirect cost and routine cost components for subsequent fiscal years.

82.1 Adjustments to the Median Base Year and Upper Limit Computation for the Indirect and Routine Cost Components. The Department of Human Services in computing the base year median and upper limits for the routine and indirect cost components will rely on the most recent available data from cost report data files. To the extent that the data on this file is unaudited data, the computation will be recomputed when base year audits on all nursing facilities have been settled to determine the variance between the initial computations and the audited data computations. If the variance is material (+ or - 1%) the rates in a subsequent period following the recalculation of the median will be adjusted to reflect the audited data.

82.2 A cost report is settled if there is no request for reconsideration of the Division of Audits findings made within the required time frame or, if such request for reconsideration was made and the Division of Audit has issued a final revised audit report.

84 FINAL AUDIT OF FIRST AND SUBSEQUENT PROSPECTIVE YEARS.

84.1 Principle. All facilities will be required to submit a cost report in accordance with Section 32 at the end of their fiscal year on cost report forms approved by the Department. The Department will conduct a final audit of each facility's cost report, which may consist of a full scope examination by Department personnel and which will be conducted on an annual basis.

84.2 Upon final audit of a facility's cost report for the first and subsequent prospective years, the Department will:

84.2.1 determine the actual allowable fixed costs incurred by the facility in the prior fiscal year,

84.2.2 determine the occupancy levels of the nursing facility,

84.2.3 The Division of Audit can make determinations required to implement these Principles of Reimbursement. The following are examples of such determinations:

84.2.3.1 Savings for the direct patient care cost component, to be determined by computing the difference between the actual costs and the direct patient care cost component rates paid during the facilities year.

84.2.3.2 Nursing facilities that transfer a cost center from one cost component to another cost component resulting in increased Medicaid costs will have the affected cost components adjusted at time of audit.

84.2.3.3 calculate a final rate,

84.2.3.4 calculate any adjustments necessary to the current prospective rates for all nursing facility's based on the above determination, and

84.2.3.5 after adjusting for the base year audited cost reports specified in 82.1 above, subsequent fiscal years costs in the indirect and routine cost components will only be adjusted for inflation using the factors specified in Section 91 of these Principles.

Upon final audit of a facility's cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amounts either due to or from the nursing facility.

84.2.4 The Division of Audit final audit adjustment to the nursing facilities annual cost report will consider the impact of days waiting placement as specified in the Principles of Reimbursement for Residential Care Facilities. Fixed cost reimbursement for the nursing facility will not be affected by days waiting placement reimbursement to the nursing facilities.

85 SETTLEMENT OF FIXED EXPENSES

85.1 The Department will reimburse facilities for the actual allowable fixed costs which are incurred during a fiscal year. Upon final audit of a facility's cost report, if the Department's share of the allowable fixed costs actually incurred by the facility is greater than the amount paid by the Department (the fixed cost component of the final prospective rate multiplied by the number of days of care provided to Medicaid beneficiaries), the difference will be paid to the facility by the Department. If, the Department's appropriate share of the allowable fixed costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

85.2 Federal regulations state that during the first year of implementing the nursing home reform requirements, the new costs which a facility must incur to comply with these requirements will be treated as a fixed cost. The facility must maintain the appropriate documentation in order for these costs to be identified at the time of the facility's final audit.

The cost associated with meeting the Nursing Home Reform Act of 1987 requirements will continue to be treated as a fixed cost through the facility's first full fiscal year after September 30, 1991 and will not be included in the determination of incentive payments which the facility might be entitled to receive as a result of its performance during that year. Thereafter, the cost associated with implementing the Nursing Home Reform Act of 1987 will be considered in the appropriate cost component and will be added to the facility's final prospective rate.

Upon final audit of a facility's cost report, if the Department's share of the allowable OBRA costs actually incurred by the facility is greater than the amount paid by the Department, the Department will pay the facility the difference. If on the other hand, the Department's appropriate share of the allowable OBRA costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

86 ESTABLISHMENT OF PEER GROUP AND INCENTIVE PAYMENTS

86.1 Establishment of Peer Group. All Nursing care facilities will be included in one of two peer groups. Hospital based nursing facilities (excluding governmental institutions) will comprise one peer group, all other nursing facilities will be included in the second peer group. Please refer to Appendix C for a description of a hospital based nursing facility. It should be noted that the establishment of these two peer groups in developing a payment model is not an accepted model in determining the upper limits as established by Federal Statute. The Federal Statute recognizes free standing nursing facilities in determining the upper limit. The upper limit for hospital based facilities is based on one-half the routine costs of freestanding facilities and one-half the costs of hospital based facilities. Therefore, the appropriate Medicare upper limit test will be applied to all nursing facilities.

86.2 The relationship between each facility's direct, indirect and routine allowable cost per day as determined in Section 80 of these Principles and those of its peers will be determined once a year. The peer groups will form the basis for determining the median indirect and routine costs. The peer groups will be subject to the same upper limits.

87 SECOND AND SUBSEQUENT YEAR FINAL PROSPECTIVE RATE.

Upon final audit of a facility's cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amounts either due to or from the nursing facility.

"Second and Subsequent Year" for purpose of this section shall mean the second full twelve (12) month fiscal year of the facility's operation following implementation of the October 1,1992 Principles of Reimbursement.

88 CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS.

Upon determination of the final rate as outlined in section 84 above, the Department will calculate the net amount of any overpayments or underpayments made to the facility.

If the Department determines that it has underpaid a facility, the Department will estimate the amount due and forward the result to the facility within thirty days. If the Department determines that it has overpaid a facility, the Department will so notify the facility. Facilities will pay the total overpayment within sixty (60) days of the notice of overpayment or request the Department to reduce facility payments during the balance of its fiscal year by the amount of the overpayment. Facilities that do not notify the Department of the method by which they intend to repay the overpayment will, beginning 60 days after their receipt of the notice of overpayment, have their subsequent payments from the Department reduced by the amount of overpayment.

If a facility appeals a determination of overpayment, the facility must repay within sixty (60) days of the notice of overpayment all portions of the determined overpayment except those that are expressly disputed and for which specific dollar values are identified. Repayment of each such specifically disputed portion and identified amount shall be stayed pending resolution of the dispute with respect thereto. The amount of money in dispute must be identified in the manner outlined in Section 150.

The net amount of any over or underpayment made to the facility will be based on 1) the calculation of actual fixed expenses incurred in the prior year, 2) the amount of savings, if any, earned by a facility and 3) the estimated difference in amount due or paid based on the interim versus final prospective rate.

89 BEDBANKING OF NURSING FACILITY BEDS

89.1 Any bedbanking request must be submitted to the Department for review by the Bureau of Elder and Adult Services and the Bureau of Medical Services. Nursing facilities are permitted to bank nursing facility beds, according to the guidelines contained in Title 22, Section 304, providing the space left vacant in the facility is not used for the creation of private rooms. In addition to those guidelines, a floor plan must be submitted to

the Bureau of Elder and Adult Services which describes the intended use of the banked bed spaces. This floor plan will be reviewed by the Department. Reimbursement of costs associated with the banked beds will be allowed to the extent that such costs have been approved by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

89.11 the use of the space is not reimbursable under the criteria contained in these Principles,

89.12 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

89.13 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space).

89.2 Pursuant to Title 22, Section 304, the following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the banking of the beds. Total bed days used to calculate this percentage will be the audited days (as filed if audited days are not available) from the base year cost report. (e.g. If a facility decreased the number of beds by 25%, and the total bed days in the base year equals 40000 and the facility was at 90% occupancy = 36000 days, then the bed days used in the calculation of the rate after the bedbanking would equal 90% of 30000 days or 27000 days.) This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year:

89.21 Indirect Patient Care Cost Component

89.21.1 Food Costs
89.21.2 Medical Supplies

89.22 Routine Cost Component

89.22.1 Administrative and Management Ceiling.
89.22.2 Housekeeping Supplies
89.22.3 Laundry Supplies
89.22.4 Dietary Supplies
89.22.5 Patient Activity Supplies
89.22.6 Medicine and Drugs

89.3 Direct Patient Care Cost Component - The Direct Patient Care Cost Component will be decreased, subject to Licensing and Certification Regulations, by a percentage equal to 50% of the total percentage decrease based on the audited costs (as filed, if audited costs are not available) in the base year for the following areas:

89.31 RNs

89.32 LPNs
89.33 CNAs. CMAs
89.34 Contract Nursing
89.35 Payroll Benefits and taxes for 89.31 through 89.34

(e.g. Using the example in 89.2 of a 25% decrease, if the total audited costs (as filed, if audited costs are not available) of the RNs. LPNs, CNAs, CMAs, Contract Nursing, and benefits and taxes were $400,000 in the base year, the allowable costs for this component would be reduced by $50,000 or 12.5%. The ratio of labor costs to benefits and taxes as contained in the base year cost report would be used in the determination of the amounts decreased in each of those areas.)

90 DECERTIFICATION/DELICENSING OF NURSING FACILITY BEDS

90.1 Pursuant to Title 22, Section 304, any request for delicensing/decertification of nursing facility beds must be submitted to the Department for review by Bureau of Medical Services. In addition to those guidelines, a floor plan must be submitted to the Bureau of Medical Services which describes the intended use, if any, of the space that the beds previously occupied. This floor plan will be reviewed by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

90.11 the use of the space is not reimbursable under the criteria contained in these Principles,

90.12 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

90.13 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space).

90.2 The following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the delicensing/decertification of the beds. Total bed days used to calculate this percentage will be the audited days (as filed if audited days are not available) from the base year cost report. The example used in Section 89.2 to also applicable to this section. This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year:

90.21 Indirect Patient Care Cost Component

90.21.1 Food Costs
90.21.2 Medical Supplies and Drugs

90.22 Routine Cost Component

90.22.1 Administrative and Management Ceiling.
90.22.2 Housekeeping Supplies
90.22.3 Laundry Supplies
90.22.4 Dietary Supplies
89.22.5 Patient Activity Supplies
89.22.6 Medicine and Drugs

90.3 Direct Patient Care Cost Component - The Direct Patient Care Cost Component will be decreased, subject to Licensing and Certification Regulations, by a percentage equal to 50% of the total percentage decrease based on the audited costs (as filed, if audited costs are not available) in the base year for the following areas:

90.31 RNs
90.32 LPNs
90.33 CNAs, CMAs
90.34 Contract Nursing
90.35 Payroll Benefits and taxes for 90.31 through 90.34.

(e.g. Using the example in 89.2 of a 25% decrease, if the total audited costs (as filed, if audited costs are not available) of the RNs, LPNs, CNAs, CMAs, Contract Nursing, and benefits and taxes were $400,000 in the base year, the allowable costs for this component would be reduced by $50,000 or 12.5%. The ratio of labor costs to benefits and taxes as contained in the base year cost report would be used in the determination of the amounts decreased in each of those areas.)

91 INFLATION ADJUSTMENT

91.1 The Maine Health Care Facility Economic Trend Factor will be used to forecast the expected increases in the cost of the goods and services which must be purchased by nursing care facilities.
The cost components, weights, proxies and method by which the Maine Health Care Facility Economic Trend Factor will be calculated are as follows:

91.1.1 Cost components: 1) wages and salaries, 2) employee benefits, 3) food, 4) fuel and other utilities, and 5) other expenses.

91.1.2 Cost component weights: The Department will use the most recent Nursing Facility Weights as published by Data Resources, Inc., of Washington, D.C.

91.1.3 Cost compensation proxy: The Department will use the most recent Nursing Facility %MOVAVG, published by Data Resources, Inc., of Washington, D.C., for all cost components except for employee wages and salaries.

The proxy for wages and salaries to be used in the Maine Health Care Facility Economic Trend Factor which will be calculated by the Department. The proxy for wages and salaries will equal the sum of the Maine specific weights for professional and technical workers and service workers times the cost compensation proxies used by the Maine Health Care Finance Commission for the same category of workers. The relative weights will be calculated every three years by the Department based on a study of the relative total costs of these categories of workers in all Maine nursing homes for the most recent available year.

91.1.4 The Maine Health Care Facility Economic Trend Factor is equal to the sum of the product of a) the cost component weight, and b) the cost compensation proxy component.

The Division of Audit shall use the most recent available publications of the applicable compensation cost proxies as published by Data Resources, Inc., for the Maine Health Care Finance Commission.

92 REGIONS

The regions shall be the regions defined by the Maine Health Care Finance Commission for hospitals. The regions are:

Region I - Cumberland County, Knox County, Lincoln County, Sagadahoc County, and York County.

Region II - Androscoggin County, Franklin County, Kennebec County, Oxford County, and Somerset County.

Region III - Penobscot County, Piscataquis County, Waldo County, Hancock County, and Washington County.

Region IV - Aroostook County

93 DAYS WAITING PLACEMENT

Reimbursement to nursing facilities for days waiting placement are governed by the regulations specified in the Principles of Reimbursement for Residential Care Facilities.

100 SUPPLEMENTAL PAYMENT

Per Maine Public Law 1999, Chapter 16, the Maine State Legislature appropriated $1,250,000 for the sole purpose of providing funds for a one-time supplemental payment to nursing facilities for the purpose of addressing the problem of recruitment and retention of non-administrative staff. This money will be disbursed to nursing facilities during State Fiscal Year 2000. Non-adminstrative staff will consist of staff within the Direct Care Component, as cited in Section 41.1; Social Services personnel within the Indirect Care Component; and dietary, housekeeping, laundry, and maintenance personnel within the Routine Cost Component. This will not include contract nursing. The following guidelines will be followed in the calculation and final audit settlement of this supplemental allowance.

Effective 7/1/99